CITIZENS
CARE AND REHABILITATION CENTER

1900 Rosemont Avenue Frederick MD 21702 ▪ (301) 600-1550 ▪ FAX (301) 600-2370
www.frederickcountymd.gov/citizenscenter

APPLICATION FOR ADMISSION

Personal Information

Name of Resident: _____ Date: _____

Home Address: _____
(Street Address) (City) (State) (Zip Code)

Gender: [ ] Male [ ] Female Age: _____ Date of Birth: _____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

U.S. Citizen: [ ] Yes [ ] No Social Security Number: _____ - _____ - _____

Current Residence: [ ] Hospital [ ] Skilled Nursing Center [ ] Assisted Living [ ] Home [ ] Other

Date of Admission to Hospital: _____ Hospitalization with 30 days? [ ] Yes [ ] No

Address of Current Residence: _____
(Street Address) (City) (State) (Zip Code)

Proposed Discharge Location: [ ] Home [ ] Assisted Living [ ] Other

Name of Proposed Discharge Location: _____

Address of Proposed Discharge Location: _____
(Street Address) (City) (State) (Zip Code)

Name of Spouse/Responsible Party: _____

Home Address of Spouse/Responsible Party: _____
(Street Address) (City) (State) (Zip Code)

Spouse/Responsible Party Telephone Numbers: _____
(Home) (Work) (Mobile)

Medical Information

Primary Care Physician: _____
(Name)

_____
(Street Address) (City) (State) (Zip Code)

Current Health Issues: _____

_____

Medicare Number: _____ [ ] Part A [ ] Part B

Any Other Health or Long Term Care Insurance? [ ] No [ ] Yes

If "Yes" (provide copy of the insurance card): _____
(Name of Insurance Company) (Policy Number)

If Resident is unable to make financial/medical decisions, who is responsible?

Name: _____ Relationship to Resident: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Telephone Numbers: _____
(Home) (Work) (Mobile)

Email Address: _____

Additional Relatives/Significant Others:

Name: _____ Relationship to Resident: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Telephone Numbers: _____
(Home) (Work) (Mobile)

Email Address: _____

Name _____ Relationship to Resident: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Telephone Numbers: _____
(Home) (Work) (Mobile)

Email Address: _____

Financial Information

The following information is required concerning the resident's finances. Please indicate the resources which are available to pay for the cost of care. The information supplied with be strictly confidential and will be used to assist you in your long-term planning.

Has anyone been appointed Power of Attorney/Guardian? [ ] Yes [ ] No

If "Yes", who? _____ [ ] Financial Decisions [ ] Medical Decisions
(Name)

Is the resident planning to apply for Maryland Medical Assistance? [ ] Yes [ ] No

If the resident has applied, what was the date of application? _____ Where? _____
(Date) (County)

Resident's Monthly Income

Salary $ _____
Social Security _____
Pensions/Annuities/IRA _____
Interest/Dividend Income _____
Other: _____ _____
(specify)

Resident' Cash Assets

Institution Name _____ Balance in Account $ _____
Institution Name _____ Balance in Account $ _____
Securities (Stocks, Bonds, IRAs) _____
(specify)

Resident's Real Estate Assets

Does the resident own a home? [ ] Yes [ ] No Value $ _____

Resident's Life Insurance

[ ] Yes [ ] No Company Name: _____ Value $ _____

Resident's Liabilities

Home Mortgage $ _____
Credit Cards/Charge Accounts _____
Loans/Taxes Owed _____

PAYMENT TERMS

It is the policy of Citizens Care and Rehabilitation Center to collect the equivalent of one month's room charge in advance and at the beginning of each subsequent month. Resident bills are owed monthly and the amount due is payable upon receipt. Amounts unpaid by the end of the month will be subject to late charges as provided in the Admissions Agreement.

PLEASE SIGN BELOW:

I hereby affirm that, to the best of my knowledge, the financial information provided is accurate and complete and that the assets listed are available to pay for the resident's care at Citizens Care and Rehabilitation Center. The nursing center has my permission to obtain a credit report of the application or contact any of the financial institutions listed herein.

Signature of Health Care Agent _____ Date: _____

Signature of Health Care Agent _____ Date: _____

In order to complete the application, a copy of the following documents must be provided:

- Medicare Card
- Medicaid Card
- Social Security Card
- Living Will
- Private Insurance Card
- Power of Attorney – Medical and /Financial